		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042085

Facility Name: Renaissance At South Shore

Address: 2425 East 71St St. (Number) Chicago (City) 60616 (Zip Code)

County: Cook

Telephone Number: (773) 721-5000 **Fax #** (773) 721-6850

IDPA ID Number: 363938428001

Date of Initial License for Current Owners: 10/23/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Noshir R. Daruwalla, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	246	Skilled (SNF)	246	90,036	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	246	TOTALS	246	90,036	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	69,285	1,833	14,531	85,649	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	69,285	1,833	14,531	85,649	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.13%

D. How many bed-hold days during this year were paid by Public Aid?
988 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/23/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/23/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 246 and days of care provided 10,957

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	356,746	50,777	8,955	416,478		416,478		416,478			1
2	Food Purchase		383,750		383,750	(20,642)	363,108	(82)	363,026			2
3	Housekeeping	221,854	54,931		276,785		276,785		276,785			3
4	Laundry	97,720	26,327		124,047		124,047		124,047			4
5	Heat and Other Utilities			192,744	192,744		192,744	(15,998)	176,746			5
6	Maintenance	123,791	33,204	119,845	276,840		276,840	5,101	281,941			6
7	Other (specify):*											7
8	**TOTAL General Services**	800,111	548,989	321,544	1,670,644	(20,642)	1,650,002	(10,979)	1,639,023			8
	B. Health Care and Programs											
9	Medical Director			30,827	30,827		30,827		30,827			9
10	Nursing and Medical Records	3,595,167	210,593	25,254	3,831,014		3,831,014	(12,001)	3,819,013			10
10a	Therapy	86,483		2,953	89,436		89,436		89,436			10a
11	Activities	196,505	3,200	1,804	201,509		201,509		201,509			11
12	Social Services	123,712		2,491	126,203		126,203		126,203			12
13	Nurse Aide Training											13
14	Program Transportation			5,933	5,933		5,933		5,933			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,001,867	213,793	69,262	4,284,922		4,284,922	(12,001)	4,272,921			16
	C. General Administration											
17	Administrative	240,340		565,671	806,011		806,011	(468,061)	337,950			17
18	Directors Fees											18
19	Professional Services			86,085	86,085		86,085	(16,785)	69,300			19
20	Dues, Fees, Subscriptions & Promotions			115,218	115,218		115,218	(78,833)	36,385			20
21	Clerical & General Office Expenses	369,224	49,377	331,242	749,843		749,843	(138,707)	611,136			21
22	Employee Benefits & Payroll Taxes			944,370	944,370	20,642	965,012		965,012			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,142	6,142		6,142	386	6,528			24
25	Other Admin. Staff Transportation			2,000	2,000		2,000	106	2,106			25
26	Insurance-Prop.Liab.Malpractice			347,084	347,084		347,084	81	347,165			26
27	Other (specify):*							34,206	34,206			27
28	**TOTAL General Administration**	609,564	49,377	2,397,812	3,056,753	20,642	3,077,395	(667,607)	2,409,788			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,411,542	812,159	2,788,618	9,012,319		9,012,319	(690,587)	8,321,732			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Renaissance At South Shore #0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			118,435	118,435		118,435	220,169	338,604			30
31	Amortization of Pre-Op. & Org.			7,522	7,522		7,522		7,522			31
32	Interest							682,116	682,116			32
33	Real Estate Taxes			692,415	692,415		692,415		692,415			33
34	Rent-Facility & Grounds			1,658,154	1,658,154		1,658,154	(1,658,154)				34
35	Rent-Equipment & Vehicles			13,432	13,432		13,432	4,832	18,264			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,489,958	2,489,958		2,489,958	(751,037)	1,738,921			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	16,048	384,569	485,990	886,607		886,607		886,607			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			135,054	135,054		135,054		135,054			42
43	Other (specify):*	30,308			30,308		30,308	(30,308)				43
44	**TOTAL Special Cost Centers**	46,356	384,569	621,044	1,051,969		1,051,969	(30,308)	1,021,661			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,457,898	1,196,728	5,899,620	12,554,246		12,554,246	(1,471,932)	11,082,314			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(230,659)	30		9
10	Interest and Other Investment Income	(84,710)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(82)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(665)	24		19
20	Contributions	(33,175)	20		20
21	Owner or Key-Man Insurance	(14,125)	21		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(125,507)	21		24
25	Fund Raising, Advertising and Promotional	(43,575)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,877)	20		28
29	Other-Attach Schedule	(310,549)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (845,924)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(626,008)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (626,008)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,471,932)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Renaissance At South Shore

ID# 0042085

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. Income	$ (1,480)	21	1
2	Patient Needs	(8,407)	10	2
3	Patient Clothing	(3,594)	10	3
4	Cable	(19,507)	5	4
5	Bank Charges	(20,461)	21	5
6	Theft Expense	(2,500)	21	6
7	Non-Allowable Salary	(36,198)	21	7
8	Marketing Salary	(3,449)	43	8
9	Building Company - Bank Charges	(360)	21	9
10	Building Company - Professional Fees	(9,560)	19	10
11	Building Company - Management Fees	(26,804)	17	11
12	Building Company - State Income Tax	(1,315)	21	12
13	Building Company - Trust Fees	(250)	20	13
14	COPE Dues	(4,501)	20	14
15	Marketing Consultant	(4,500)	19	15
16	Undocumented Professional Fees	(2,219)	19	16
17	Non-allowable Legal	(12,388)	19	17
18	Building Company - Amortization	(6,037)	31	18
19	Building Company - Misc Fees	(160)	21	19
20	Non-Allowable Expense	(120,000)	21	20
21	Non-Allowable Salary	(26,859)	43	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
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95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(310,549)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(82)											(82)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(19,507)				3,509							(15,998)	5
6	Maintenance					5,101							5,101	6
7	Other (specify):*													7
8	**TOTAL General Services**	(19,589)				8,610							(10,979)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(12,001)											(12,001)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(12,001)											(12,001)	16
	C. General Administration													
17	Administrative	(26,804)	26,804	(113,054)	581	(355,588)							(468,061)	17
18	Directors Fees													18
19	Professional Services	(28,667)	9,560	366	340	1,616							(16,785)	19
20	Fees, Subscriptions & Promotions	(84,378)	250		151	5,144							(78,833)	20
21	Clerical & General Office Expenses	(322,106)	1,835	1,048	1,726	178,790							(138,707)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(665)				1,051							386	24
25	Other Admin. Staff Transportation					106							106	25
26	Insurance-Prop.Liab.Malpractice					81							81	26
27	Other (specify):*			790	3,753	29,663							34,206	27
28	**TOTAL General Administration**	(462,620)	38,449	(110,850)	6,551	(139,137)							(667,607)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(494,210)	38,449	(110,850)	6,551	(130,527)							(690,587)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Renaissance At South Shore** **#** **0042085** **Report Period Beginning:** **01/01/04** **Ending:** **12/31/04**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(230,659)	442,093			8,735							220,169	30
31	Amortization of Pre-Op. & Org.	(6,037)	6,037											31
32	Interest	(84,710)	764,524			2,302							682,116	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(1,658,154)										(1,658,154)	34
35	Rent-Equipment & Vehicles					4,832							4,832	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(321,406)	(445,500)			15,869							(751,037)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(30,308)											(30,308)	43
44	**TOTAL Special Cost Centers**	(30,308)											(30,308)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(845,924)	(407,051)	(110,850)	6,551	(114,658)							(1,471,932)	45

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				South Shore Limited Partnership		Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,658,154	South Shore Limited Partnership	100.00%	$	$ (1,658,154)	1
2	V	32	Interest Income	4,123	South Shore Limited Partnership			(4,123)	2
3	V	31	Amortization		South Shore Limited Partnership		6,037	6,037	3
4	V	21	Bank Charges		South Shore Limited Partnership		360	360	4
5	V	30	Depreciation		South Shore Limited Partnership		442,093	442,093	5
6	V	32	Interest Expense		South Shore Limited Partnership		768,647	768,647	6
7	V	19	Professional Fees		South Shore Limited Partnership		9,560	9,560	7
8	V	17	Management Fees		South Shore Limited Partnership		26,804	26,804	8
9	V	21	State Income Tax		South Shore Limited Partnership		1,315	1,315	9
10	V	20	Trust Fees		South Shore Limited Partnership		250	250	10
11	V	21	Miscellaneous		South Shore Limited Partnership		160	160	11
12	V								12
13	V								13
14	Total			$ 1,662,277			$ 1,255,226	$ * (407,051)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	J. RAJCHENBACH-COMP.	$	JLR MANAGEMENT CORP.	100.00%	$ 6,946	$ 6,946	15
16	V	19	PROFESSIONAL FEES		JLR MANAGEMENT CORP.		366	366	16
17	V	21	OFFICE		JLR MANAGEMENT CORP.		1,048	1,048	17
18	V	27	PAYROLL TAXES		JLR MANAGEMENT CORP.		790	790	18
19	V								19
20	V								20
21	V	17	MARVIN NEEDLE-CONS. FEES		JLR MANAGEMENT CORP.				21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V	17	MANAGEMENT FEES	120,000	JLR MANAGEMENT CORP.			(120,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 120,000			$ 9,150	$ * (110,850)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	CAREPATH HEALTH NETWORK	100.00%	$ 17,681	$ 17,681	15
16	V	19	PROFESSIONAL FEES		CAREPATH HEALTH NETWORK		340	340	16
17	V	20	FEES, SUBSCRIPTIONS		CAREPATH HEALTH NETWORK		151	151	17
18	V	21	CLERICAL AND GENERAL		CAREPATH HEALTH NETWORK		1,726	1,726	18
19	V	27	GEN ADMIN.- EMP. BEN.		CAREPATH HEALTH NETWORK		3,753	3,753	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V	17	MANAGEMENT FEES	17,100	CAREPATH HEALTH NETWORK			(17,100)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 17,100			$ 23,651	$ * 6,551	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	NUCARE SERVICES CORP.	100.00%	$ 3,509	$ 3,509	15
16	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.		5,101	5,101	16
17	V	17	ADMINISTRATIVE - NON-OWNER		NUCARE SERVICES CORP.		34,688	34,688	17
18	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.		1,616	1,616	18
19	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.		5,144	5,144	19
20	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.		178,790	178,790	20
21	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.		1,051	1,051	21
22	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.		106	106	22
23	V	26	INSURANCE		NUCARE SERVICES CORP.		81	81	23
24	V	27	EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.		26,823	26,823	24
25	V	30	DEPRECIATION		NUCARE SERVICES CORP.		8,735	8,735	25
26	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.		2,302	2,302	26
27	V	34	BUILDING RENT		NUCARE SERVICES CORP.				27
28	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.		4,832	4,832	28
29	V	17	MANAGEMENT FEES	428,571	NUCARE SERVICES CORP.			(428,571)	29
30	V	17	ADMIN. - R. HARTMAN		NUCARE SERVICES CORP.		20,203	20,203	30
31	V	17	ADMIN. - B. CARR		NUCARE SERVICES CORP.		18,092	18,092	31
32	V	17	ADMIN. - D. HARTMAN		NUCARE SERVICES CORP.				32
33	V	27	EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.		1,916	1,916	33
34	V	27	EMP. BEN. - B. CARR		NUCARE SERVICES CORP.		924	924	34
35	V	27	EMP. BEN. - D. HARTMAN		NUCARE SERVICES CORP.				35
36	V								36
37	V								37
38	V								38
39	Total			$ 428,571			$ 313,913	$ * (114,658)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		22	Workmans Compensation	$ 66,463	Diamond Insurance	40.00%	$ 66,463	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 66,463			$ 66,463	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Robert Hartman	Owner	Administrative	20.05%	See Attached	3.71	7.42%	Allocated	$ 20,203	17-7	1
2	Bernard Hollander	Owner	Administrative	25.00%	See Attached	2.00	3.08%				2
3	Barry Carr	Administrative	Administrative		See Attached	5.31	10.62%	Allocated	18,092	17-7	3
4	Jack Rajchenbach	Owner	Administrative	25.00%	See Attached	5.00	7.69%	Alloc. JLR	6,945	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 45,240		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: JLR MANAGEMENT CORP.
Street Address: 6633 NORTH LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 679-9141
Fax Number: (847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	55	10	$ 76,400	$ 76,400	5	$ 6,946	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	55	10	4,020		5	366	2
3	21	OFFICE	AVG. HOURS WORKED	55	10	11,524	9,614	5	1,048	3
4	27	PAYROLL TAXES	AVG. HOURS WORKED	55	10	8,689		5	790	4
5										5
6										6
7	17	MARVIN NEEDLE-CONS. FEES	AVG. HOURS WORKED	40	1	36,296				7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 136,929	$ 86,014		$ 9,150	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPATH HEALTH NETWORK
Street Address: 6633 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (888) 707-6700
Fax Number: (847) 679-2150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	227,090	9	$ 234,811	$ 234,811	17,100	$ 17,681	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	227,090	9	4,511		17,100	340	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	227,090	9	2,000		17,100	151	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	227,090	9	22,918		17,100	1,726	4
5	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	227,090	9	49,841		17,100	3,753	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 314,081	$ 234,811		$ 23,651	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 7257 N. LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	756,764	9	$ 29,620	$	89,660	$ 3,509	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	756,764	9	43,055		89,660	5,101	2
3	17	ADMINISTRATIVE - NON-OWN	AVAIL. CENSUS DAYS	756,764	9	292,782	286,867	89,660	34,688	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	756,764	9	13,637		89,660	1,616	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	756,764	9	43,417		89,660	5,144	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	756,764	9	1,509,058	1,239,144	89,660	178,790	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	756,764	9	8,870		89,660	1,051	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	756,764	9	894		89,660	106	8
9	26	INSURANCE	AVAIL. CENSUS DAYS	756,764	9	682		89,660	81	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	756,764	9	226,398		89,660	26,823	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	756,764	9	73,728		89,660	8,735	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	756,764	9	19,426		89,660	2,302	12
13	34	BUILDING RENT	AVAIL. CENSUS DAYS	756,764	9			89,660		13
14	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	756,764	9	40,782		89,660	4,832	14
15										15
16	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	31	9	170,000	170,000	4	20,203	16
17	17	ADMIN. - B. CARR	AVG. HOURS WORKED	45	9	152,234	152,234	5	18,092	17
18	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED	8	9	55,558	54,772			18
19	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	31	9	16,119		4	1,916	19
20	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	45	9	7,772		5	924	20
21	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	8	9	4,305				21
22										22
23										23
24										24
25	TOTALS					$ 2,708,337	$ 1,903,018		$ 313,913	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Diamond Insurance
Street Address: 40 Skokie Blvd, Suite 105
City / State / Zip Code: Northbrook, IL 60062
Phone Number: (847) 559-1002
Fax Number: (847) 562-0070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Workmans Compensation	Direct Allocation			$	$		$ 66,463	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 66,463	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Shareholder Loan		X	Mortgage			$	$ 8,909,605			$ 768,647	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Allocated Nucare Services		X								2,302	6
7												7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 8,909,605			$ 770,949	9
	B. Non-Facility Related*											
10	Interest Income		X								(24,762)	10
11	Interest Income - BLVD		X								(45,895)	11
12	Interest Income - SJV		X								(9,369)	12
13	See Supplemental Schedule										(8,807)	13
14	TOTAL Non-Facility Related						$	$			$ (88,833)	14
15	TOTALS (line 9+line14)						$	$ 8,909,605			$ 682,116	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15	Interest Income - HLP		X				$	$			$ (4,684)	15
16	Interest Income - Bldg Co.		X								(4,123)	16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										(8,807)	20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	409,503	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	355,282	2
3. Under or (over) accrual (line 2 minus line 1).	$	(54,221)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	746,636	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	692,415	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	408,698	8
	2000	360,670	9
	2001	385,679	10
	2002	390,003	11
	2003	355,282	12

Accrual = 355,282 x 1.05

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Renaissance At South Shore COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042085

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-30-101-003-0000	Long Term Care Property	$ 26,811.39	$ 26,811.39
2.	21-30-101-004-0000	Long Term Care Property	$ 50,400.37	$ 50,400.37
3.	21-30-101-014-0000	Long Term Care Property	$ 142,218.51	$ 142,218.51
4.	21-30-101-022-0000	Long Term Care Property	$ 41,402.27	$ 41,402.27
5.	21-30-101-023-0000	Long Term Care Property	$ 94,449.37	$ 94,449.37
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 355,281.91	$ 355,281.91

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Renaissance At South Shore COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042085

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 80,865 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 273,032
2. Number of Years Over Which it is Being Amortized: 5, 39 yrs
3. Current Period Amortization: 7,522
4. Dates Incurred: 2002, 1998

Nature of Costs: Loan Fees, Permanent Mortgage Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	42,825		$ 651,589	1
2				4,750	2
3	TOTALS	42,825		$ 656,339	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1998	78,106		20	3,906	3,906	24,043	9
10	Various			1999	88,720		20	4,438	4,438	24,974	10
11	Various			2000	72,602		20	3,633	3,633	16,941	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		9,209,684	442,093		263,134	(178,959)	1,837,056	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		73,105	2,229		2,312	83	2,472	68
69	Financial Statement Depreciation			68,418			(68,418)		69
70	TOTAL (lines 4 thru 69)		$ 9,522,217	$ 512,740		$ 277,423	$ (235,317)	$ 1,905,486	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 9,522,217	$ 512,740		$ 277,423	$ (235,317)	$ 1,905,486	1
2	Wanderguard	2001	1,341		20	67	67	268	2
3	Wallpaper	2001	1,241		20	62	62	243	3
4	Wallpaper	2001	608		20	30	30	119	4
5	Earl Moore	2001	1,000		20	50	50	188	5
6	Replace Sprinklers	2001	8,791		20	440	440	1,759	6
7	Electric Work	2001	2,410		20	121	121	433	7
8	Carpteting	2001	2,007		20	100	100	359	8
9	Wallpaper	2001	897		20	45	45	161	9
10	Wanerguard	2001	1,045		20	52	52	187	10
11	Flooring	2001	8,685		20	434	434	1,556	11
12	Wanderguard	2001	2,131		20	107	107	382	12
13	Wanderguard	2001	1,341		20	67	67	246	13
14	Wanderguard	2001	762		20	38	38	139	14
15	Wanderguard	2001	1,045		20	52	52	187	15
16	Oxygen Storage Const	2001	1,998		20	100	100	350	16
17	Irrigation Sys Repai	2001	527		20	26	26	90	17
18	Irrigation Sys Repai	2001	592		20	30	30	102	18
19	Tiles	2001	580		20	29	29	99	19
20	Parking Lot Repair	2001	6,464		20	323	323	1,024	20
21	Wanderguard	2001	779		20	39	39	130	21
22	Winterize Sprinklers	2001	1,385		20	69	69	277	22
23	Shades	2002	970		20	97	97	291	23
24	Recircuit Hallways	2002	1,000		20	100	100	283	24
25	Drywall	2002	3,558		20	356	356	1,038	25
26	Parking Lot Sealer	2002	1,661		20	166	166	443	26
27	Drywall - Sandstone	2002	3,396		20	340	340	962	27
28	Painting & Decorating	2002	1,172		20	117	117	352	28
29	Sandstone Wall	2003	1,361		20	136	136	261	29
30	Screen Insert	2003	1,183		20	118	118	227	30
31	Network Connections	2003	3,400		20	340	340	623	31
32	Landscaping	2003	900		20	90	90	143	32
33	Mural Painting	2003	750		20	75	75	119	33
34	TOTAL (lines 1 thru 33)		$ 9,587,197	$ 512,740		$ 281,639	$ (231,101)	$ 1,918,527	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,587,197	$ 512,740		$ 281,639	$ (231,101)	$ 1,918,527	1
2	Wallpaper	2003	1,429		20	143	143	214	2
3	Wallpaper	2003	573		20	57	57	81	3
4	Wanderguard System	2003	2,069		20	207	207	293	4
5	Pleated Shades	2003	616		20	62	62	92	5
6	Pleated Shades	2003	774		20	77	77	103	6
7	Smoke Detectors	2003	1,134		20	113	113	161	7
8	Tiles	2003	668		20	67	67	134	8
9	Painting & Decorating	2003	1,443		20	144	144	289	9
10	Mural	2004	900		20	75	75	75	10
11	Wall Covering	2004	1,576		20	1,445	1,445	1,445	11
12	Nbw Timer	2004	758		20	69	69	69	12
13	Freezer Condensor	2004	765		20	64	64	64	13
14	Heater	2004	913		20	91	91	91	14
15	Window	2004	872		20	44	44	44	15
16	Carpeting	2004	2,235		20	133	133	133	16
17	Carpet	2004	2,554		20	122	122	122	17
18	Freezer Condensor	2004	3,525		20	147	147	147	18
19	Awning	2004	8,730		20	364	364	364	19
20	Wood Floor	2004	5,708		20	143	143	143	20
21	Cabinets	2004	9,780		20	326	326	326	21
22	Parking Lot Repair	2004	1,452		20	48	48	48	22
23	Mirrors	2004	2,400		20	60	60	60	23
24	Smoke Detectors	2004	985		20	33	33	33	24
25	Parking Garage Repair	2004	11,200		20	560	560	560	25
26	Time Clock And Stand	2004	3,519		20	29	29	29	26
27	Carpet	2004	2,200		20	92	92	92	27
28	Fire Equip	2004	2,575		20	107	107	107	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,658,550	$ 512,740		$ 286,461	$ (226,279)	$ 1,923,846	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 9,658,550	$ 512,740		$ 286,461	$ (226,279)	$ 1,923,846	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,658,550	$ 512,740		$ 286,461	$ (226,279)	$ 1,923,846	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 9,658,550	$ 512,740		$ 286,461	$ (226,279)	$ 1,923,846	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,658,550	$ 512,740		$ 286,461	$ (226,279)	$ 1,923,846	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 9,658,550	$ 512,740		$ 286,461	$ (226,279)	$ 1,923,846	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,658,550	$ 512,740		$ 286,461	$ (226,279)	$ 1,923,846	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 9,658,550	$ 512,740		$ 286,461	$ (226,279)	$ 1,923,846	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,658,550	$ 512,740		$ 286,461	$ (226,279)	$ 1,923,846	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 9,658,550	$ 512,740		$ 286,461	$ (226,279)	$ 1,923,846	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,658,550	$ 512,740		$ 286,461	$ (226,279)	$ 1,923,846	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 9,658,550	$ 512,740		$ 286,461	$ (226,279)	$ 1,923,846	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,658,550	$ 512,740		$ 286,461	$ (226,279)	$ 1,923,846	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 9,658,550	$ 512,740		$ 286,461	$ (226,279)	$ 1,923,846	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,658,550	$ 512,740		$ 286,461	$ (226,279)	$ 1,923,846	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 9,658,550	$ 512,740		$ 286,461	$ (226,279)	$ 1,923,846	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,658,550	$ 512,740		$ 286,461	$ (226,279)	$ 1,923,846	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	246		1998	1998	$ 9,209,684	$ 442,093	35	$ 263,134	$ (178,959)	$ 1,837,056	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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24											24
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 9,209,684	$ 442,093		$ 263,134	$ (178,959)	$ 1,837,056	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocated 7257 N. Lincoln Avenue, LLC		2004		$ 42,754	$ 1,096	35	$ 1,222	$ 126	$ 1,374	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated Nucare Services Corp			2003	1,388	36	20	70	34	78	9
10	Allocated Nucare Services Corp			2004	28,113	927	20	999	72	999	10
11											11
12	Allocated 7257 N. Lincoln Avenue, LLC			2004	850	170	20	21	149	21	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 73,105	$ 2,229		$ 2,312	$ 381	$ 2,472	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 430,390	$ 53,464	$ 48,588	$ (4,876)	10	$ 215,929	71
72	Current Year Purchases	70,418	3,060	3,556	496	10	3,556	72
73	Fully Depreciated Assets	17,471				10	17,471	73
74								74
75	TOTALS	$ 518,279	$ 56,524	$ 52,144	$ (4,380)		$ 236,956	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,833,168	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 569,264	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 338,605	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (230,659)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,160,802	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 18,264 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 220,149	$		$ 220,149	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			16,992			16,992	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	3,651		248,849			252,500	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				296,488		296,488	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental			12,397			88,081		100,478	13
14	TOTAL			$ 16,048		$ 485,990	$ 384,569		$ 886,607	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore **#** 0042085 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,681	$ 367,610	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,826,370	2,826,370	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	585	585	5
6	Prepaid Insurance	146,009	146,009	6
7	Other Prepaid Expenses	154,770	154,770	7
8	Accounts Receivable (owners or related parties)	259,070	346,817	8
9	Other(specify): See Attached Schedule	928,400	1,083,096	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,320,885	$ 4,925,257	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		651,589	13
14	Buildings, at Historical Cost		8,772,773	14
15	Leasehold Improvements, at Historical Cost	1,017,163	1,017,163	15
16	Equipment, at Historical Cost	469,158	1,408,312	16
17	Accumulated Depreciation (book methods)	(752,325)	(3,487,043)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		235,425	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(27,668)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	269,985	269,985	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,003,981	$ 8,840,536	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,324,866	$ 13,765,793	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,367,821	$ 1,367,821	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,270	5,270	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	329,009	329,009	30
31	Accrued Taxes Payable (excluding real estate taxes)	43,801	43,801	31
32	Accrued Real Estate Taxes(Sch.IX-B)	746,636	746,636	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	33,277	33,277	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,690,822	1,690,822	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,216,636	$ 4,216,636	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,909,605	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	(105,688)	(105,688)	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (105,688)	$ 8,803,917	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,110,948	$ 13,020,553	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,213,918	$ 745,240	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,324,866	$ 13,765,793	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 691,854	1	
2	Restatements (describe):		2	
3	**Income Restatement**	52,502	3	
4	**Expense Restatement**	(93,309)	4	
5	**Rounding**	7	5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 651,054	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	562,864	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 562,864	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,213,918	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,628,526	1
2	Discounts and Allowances for all Levels	(625,034)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,003,492	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,361,502	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,361,502	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	606,875	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	37,463	19
20	Radiology and X-Ray	7,990	20
21	Other Medical Services	38,287	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 690,615	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	60,021	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 60,021	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,480	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,480	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,117,110	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,670,644	31
32	Health Care	4,284,922	32
33	General Administration	3,056,753	33
	B. Capital Expense		
34	Ownership	2,489,958	34
	C. Ancillary Expense		
35	Special Cost Centers	916,915	35
36	Provider Participation Fee	135,054	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,554,246	40
41	**Income before Income Taxes (line 30 minus line 40)****	562,864	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 562,864	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,639	1,731	$ 78,886	$ 45.57	1
2	Assistant Director of Nursing	1,927	2,128	64,029	30.09	2
3	Registered Nurses	22,583	24,187	577,508	23.88	3
4	Licensed Practical Nurses	53,423	56,860	1,214,081	21.35	4
5	Nurse Aides & Orderlies	156,349	167,883	1,560,028	9.29	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	774	774	16,048	20.73	7
8	Rehab/Therapy Aides	6,913	6,447	86,483	13.41	8
9	Activity Director	3,791	4,207	67,337	16.01	9
10	Activity Assistants	14,319	15,599	129,168	8.28	10
11	Social Service Workers	6,825	7,653	123,712	16.17	11
12	Dietician	3,483	3,784	69,717	18.42	12
13	Food Service Supervisor					13
14	Head Cook	7,895	8,450	92,339	10.93	14
15	Cook Helpers/Assistants	24,063	25,441	194,690	7.65	15
16	Dishwashers					16
17	Maintenance Workers	7,308	7,993	123,791	15.49	17
18	Housekeepers	24,568	26,559	221,854	8.35	18
19	Laundry	11,471	12,052	97,720	8.11	19
20	Administrator	1,954	2,091	118,388	56.62	20
21	Assistant Administrator	1,970	2,091	77,321	36.98	21
22	Other Administrative	723	723	44,631	61.73	22
23	Office Manager					23
24	Clerical	26,647	28,365	369,224	13.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,282	4,437	100,635	22.68	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	766	766	30,308	39.57	33
34	TOTAL (lines 1 - 33)	383,673	410,221	$ 5,457,898 *	$ 13.30	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	191	$ 8,955	01-03	35
36	Medical Director	Monthly	30,827	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,924	10-03	39
40	Physical Therapy Consultant	39	1,853	10a-03	40
41	Occupational Therapy Consultant	22	1,076	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	24	10a-03	43
44	Activity Consultant	34	1,804	11-03	44
45	Social Service Consultant	47	2,491	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	334	$ 49,954		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	24	$ 496	10-03	50
51	Licensed Practical Nurses	8,020	21,834	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	8,044	$ 22,330		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Schechter	Administrator	0	$ 118,388
Brent Fitzgerald	Asst. Admin.	0	77,321
Kathleen Brander	VP Regulator Mgmt	0	12,619
Marilyn Flaherty	VP Medicare Reimb	0	14,947
Gerry Jenich	CEO	0	3,381
Jennifer Bebinger	Alzheimer Director	0	13,684
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 240,340

B. Administrative - Other

Description	Amount
Carepath - Network Fees	$ 17,100
Nucare Services Corp. - Management Fees	428,571
JLR Management - Management Fees	120,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 565,671

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners, Inc.	Unemployment Tax Cons	$ 3,375
Purchasing Plus	Purchasing Consultant	600
FRR	Accounting	20,965
Adjusted Out Page 5	Undocumented Prof Fees	2,219
Adjusted Out Page 5	Marketing Consultant	4,500
Giftrap	Computer	4,664
HDSI	Computer	6,882
CDW	Computer	326
PSD Solutions	Computer	7,047
Platinum Plus	Computer	428
Allocated Nucare	Computer	4,778
See Supplemetal Schedule		30,301
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 86,085

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 66,463
Unemployment Compensation Insurance	136,094
FICA Taxes	408,970
Employee Health Insurance	240,362
Employee Meals	20,642
Illinois Municipal Retirement Fund (IMRF)*	
City Payroll Tax	13,640
Union Pension Benefits	53,704
Dental Insurance	2,268
Other Employee Benefits	20,864
401K Matching Expense	2,006
TOTAL (agree to Schedule V, line 22, col.8)	$ 965,013

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,600
Health Care Worker Background Check (Indicate # of checks performed)	1,854
Dues	11,848
Subscriptions	450
Advertising & Promotion	43,575
Yellow Page Advertising	2,877
Licenses & Inspections	5,338
See Supplemental Schedule	5,295
Less: Public Relations Expense	( )
Non-allowable advertising	(43,575)
Yellow page advertising	(2,877)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,385

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,477
Allocated - Nucare Services Corp	1,051
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,528

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $13,429**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **49,689** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **135,054**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **20,642** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.